

**Reading and Evaluating Quantitative Research in
Body Psychotherapy**
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Abstract

Many arguments have been made in the literature for why research is considered important for health practitioners. One of the most important has to do with continuing growth of practitioners and guarding against falling into practices that are based only on personal opinion. While most body psychotherapists would endorse the idea that research can affect and inform practice, many would also admit that they do not regularly read quantitative or evidence-based research studies, the type of research that can be generalized to their own clients. Feeling comfortable with and using suitable criteria for reading quantitative research articles and reports is often experienced as difficult. It requires the use of concepts and information that may not be employed in everyday clinical practice settings. Reviewing that content and its associated skills can help to make it more available, so that one may adequately critique and get more out of one's professional reading and ultimately, provide better service to clients. To that end, in this paper three related areas central to understanding quantitative research are reviewed: (a) the logic of research design; (b) how internal and external validity are judged; and (c) the basics of statistical inference.

Keywords: body-oriented therapy, body psychotherapy, dance movement therapy, research methods for clinicians, quantitative research, research design.

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Introduction

In times of increasing pressure to live up to evidence-based medicine standards established by health institutions and research communities, body psychotherapists, like other therapists, feel the need to be included and contribute. The contribution to the scientific research literature most often envisioned is quantitative research studies of efficacy using randomized controlled trials. These studies are just one methodological possibility of going about answering important research questions, and they have limitations (Koch, Kunz, Lykou, & Cruz, 2014), but they are important for the survival of health professions (Meekums, 2014).

If body psychotherapists do not want to disappear from health care systems, just like other specializations they will need to be able to demonstrate in clinical studies with large numbers of homogenous patient groups that body psychotherapy approaches work.

Despite this need, practitioners may not be motivated or have access to the specialized skills and resources needed to contribute to the research base – which usually requires an academic, institutional “home” that can be used as a base for applying for grant funds – and even seasoned researchers can face prejudices in locating funding for body-oriented studies (Meekums, 2014). But conceptualizing body psychotherapy as part of a larger community of related professions and research can be useful in adding to the research basis of the field.

Dance/movement therapy (DMT) is in many ways related to body psychotherapies; in Europe it is partly regarded as one form of body psychotherapy, relying on the healing factors of the body-mind connection, and on the other hand it is a creative arts therapy, relying on the healing effects of aesthetics and creative expression. DMT has begun to contribute many evidence-based studies on its effects (e.g., Bradt, Goodill, & Dileo, 2011; Karkou & Meekums, 2014), and can be rightfully called one of the foremost contributors to evidence-based clinical literature on the effectiveness of body-mind interventions.

Body psychotherapy as a profession can draw from the research resources that are starting to accumulate in dance/movement therapy (Karkou & Warnecke, 2014), and movement behavior research that has been developing over the years (Lausberg, 2013). For example, a recent meta-analysis of effects of dance therapy and dance on psychological measures (Koch et al., 2014) documented effects on quality of life, depression, body image, and anxiety among other outcomes. In addition, there are Cochrane reviews on DMT in cancer care, schizophrenia, depression, and most recently dementia (Bradt, et al., 2011; Karkou & Meekums, 2014; Meekums, Karkou, & Nelson, 2012; Ren & Xia, 2013). To assist with developing theoretical arguments for body psychotherapy that can then be tested with research, ample findings document the relationship between movement behavior and cognitive processes, and movement behavior and emotional processes (Lausberg, 2013). A good example in the DMT literature of how research findings from other disciplines can be used to develop cogent theoretical arguments can be found in Koch and Fischman (2011). Thus, by accessing a host of resources, it may be possible to address basic research premises for body psychotherapy, paving the way for much-needed research.

Body psychotherapy practitioners can also draw on such research resources and use them to inform their clinical practice. In fact, while body-oriented therapists tend to focus on research to inform policy-makers and address inclusion in healthcare reforms (Cruz & Hervey, 2001), consuming research to increase knowledge and understanding about clinical practice is the cornerstone of professional development and the continuing education required of clinicians. It has been argued that clinical skills can inform and even overlap with research skills (Cruz & Berrol, 2012; Meekums, 2014) creating a natural relationship between the two. But there is a long history regarding the difficult relationship between clinicians of all sorts and research (Cruz & Berrol, 2012) that continues to be noted today (Karkou & Warnecke, 2014). “The marriage between research and clinical practice has not been an easy one. Research has been seen as an add-on, an external requirement, a practice imposed upon practitioners and, as a result, many cannot see its value for daily clinical practice” (Karkou & Warnecke, 2014, p. 119). The issue is really one of maintaining high quality in clinical practice and has been referred to as the research-to-practice gap, or the evidence-to-practice gap in other health disciplines such as nursing (Cruz & Berrol, 2012, p. 13). There

are practical arguments about why reading research assists therapists such as, “While each therapist conceivably builds a base of knowledge through practice, imagine how inefficient it would be for each therapist to work only from his or her own experiences. The therapist who works only from the knowledge base of personal experience becomes locked within the parameters of his or her somewhat limited world view,” (Cruz & Berrol, 2012, p. 14). There have been many perspectives presented over the years about why clinicians seem indifferent to research (Cruz & Berrol, 2012).

We argue that clinical practice is a complex endeavor that requires the therapist to hypothesize based on both knowledge and comparative data. Clients benefit when the therapist is broadly informed and engaged in reading research. In a complementary way, clinicians are best positioned from their daily work with a range of clients to pose questions and problems to researchers about how to improve care that are worthy of research. This situation was the basis for the development of the scientist-practitioner model, sometimes call the Boulder model, that was proposed for psychology in the 1940s (Baker & Benjamin, 2000).

Understanding that therapists do want to offer clients their best services and that research is an important part of maintaining professional skills, the purpose of this article is to review and explain how to read and evaluate quantitative research. Evaluating such research and its impact for treatment, requires some understanding of the hierarchy of research designs, criteria such as how to judge internal and external validity, and the basics of statistical inference.

It Starts with the Question

Research questions typically address who, what, where, why and how concerns, and of these, the first three are generally answered with quantitative methods and the last two with qualitative methods (Yin, 2013). Quantitative research uses a defined question or hypothesis that is tested using data collected from a sample that represents a larger population, for example, adults suffering from incapacitating anxiety. This type of research is useful because it can test theory to see if there is evidence to support or refute the theory and it can be generalized to and across populations. If the sample represents the population well and the research has been conducted validly, then we can safely and reasonably assume that the results might be achieved with other members of that population treated similarly. It is exactly this quality of being able to generalize research results to other people that helps clinicians deliver good service. Research using qualitative methods in which there is a guiding question rather than a hypothesis, and data collection and analysis are used in a formative way, is useful for building theory and generalizes only to theory rather than to people or other members of a population. Rather than sampling a population, in qualitative research key informants are specifically chosen creating the inability to generalize the results to a population. Useful theories are the cornerstone of research and consist of collections of ideas that predict and explain and have empirical support from quantitative research. Thus, both qualitative and quantitative methods are needed for research. But because quantitative methods are often considered more difficult to understand, this article deals exclusively with quantitative methods.

The goal of quantitative research is typically to generate probable answers to who, what, or where questions. The answers are probable because probabilistic mathematical models are used for evaluating the statistical results of the study, a topic that will be addressed in this paper. This fact also means that while one might greatly desire to ‘prove’ that body psychotherapy is effective, the best that can be done is to accumulate support for that premise! No single study establishes fact and scientific evidence has to be amassed over time.

Thinking about research questions that are common in clinical work, one might, for example, ask questions about treatment – does it work better than the absence of treatment? Is it better than the alternatives (relative efficacy), and how does it work (mediation)? Hollon (2006) presented these as the key questions quantitative researchers interested in clinical care ask.

Research Design, Internal and External Validity

Evaluating the ‘goodness’ of quantitative research studies requires understanding fundamentals of research design that is based on logic, understanding what internal and external validity are and how they are judged, and understanding statistical inference. The goal of good research design is to assist the researcher in arguing that the intervention caused whatever change was observed in participants. In the strictest sense, causation requires that three conditions be satisfied; that the treatment must precede the result, the treatment must be sufficient to cause the result, and the treatment must be necessary for the result to be observed (Cook & Campbell, 1979).

However, in the practical sense causation is commonly assisted by arguments using basic research design features such as, adding a control group which does not receive the treatment. A control group assists the researcher in arguing that the treatment group changed as a function of the treatment because the two groups, one that did receive the treatment and one that did not, can be directly compared. Randomly assigning participants to the control or the treatment group further helps the researcher to argue that the groups were not different at the beginning of the research, although it is not a guarantee. Addressing features of the research design that enhance internal validity, or controlling alternative explanations for the change observed in the treatment group, is of key importance in designing research that helps the researcher to argue causation.

Internal validity is the amount of confidence with which one can attribute change observed in the treatment group to the treatment that was delivered. It is created by controlling elements of the study design that could be used to argue for rival explanations of the results, when what is desired is to attribute the therapeutic change to the treatment (Berrol, 2012). Internal validity was nicely and concisely described by Hollon (2006) and consists of defined potential “threats” such as maturation – for example, did a group of children change due to the treatment, or did they simply mature out of their difficulties? Other threats to internal validity consist of history (other events could have occurred outside of the research that impacted one group and not the other); testing (practice and other effects of the testing might change how people responded); mortality (people may not complete the study for different reasons including that they reacted negatively to the treatment); instrumentation (measurements may not have been taken consistently or validly); spontaneous remission (people who seek treatment at their worst will get better as a function of time); and statistical regression (people selected for extreme scores will do worse or better at the next testing). See Cruz and Feder (2013) for an interesting historical discussion of statistical regression, and note that the listing here of threats to internal validity is not exhaustive. Instead, it is intended to be just enough to demonstrate the point that logically accounting for the absence of these threats in the research design aids the researcher in his or her overall aim to argue that the treatment, not other factors, was responsible for the change observed in the treatment group. The researcher must try to control the design so that there are no other possible explanations for the results – something that is easier described than done in reality in social sciences research.

External validity is the amount of confidence with which the results of a study can be generalized “to and across alternate measures of the cause and effect and across different types of persons, settings, and times” (Cook & Campbell, 1979, p. 37). It consists of the elements of a study that support generalizing results to populations and even across populations. External validity is important when judging the usefulness of research. For good external validity, the researcher needs to have very thoroughly defined the important constructs used in the research. In research, constructs are abstractions that represent people, ideas, or events, et cetera. Self-esteem is a construct as are gender and intelligence, because they are abstractions and not directly observable (as opposed to, for example, height or sex). For example, if body psychotherapy is the treatment – it becomes a construct and the researcher needs to define exactly what constitutes body psychotherapy in his or her study. But additionally, for a study to have good external validity, it is important that the sample is well-described so that it can be judged whether the sample can be considered representative of the population and whether generalization is supported.

Statistics

A final element that is required for evaluating quantitative research is statistics. The limitation of statistics needs to be stated clearly, and that is that statistics cannot fix threats to internal validity or fix a poor research design. Statistics also cannot address poorly defined constructs or errors in sampling the population, and they cannot establish causation. However, what statistics can do is very useful. Once data have been collected, statistics can summarize and be used to test if what has been found is different than what would be expected just due to chance. *Descriptive statistics* help examine the sample, for example, who the participants are in terms of gender, age, ethnicity and other characteristics or constructs of interest – even how they performed on tests that were central to the research. Common types of descriptive statistics are the mean, or arithmetic average, the median, mode, standard deviation and proportions. Using these statistics and graphs such as histograms helps one ‘see’ and understand the data (Cruz & Feder, 2013). For example, how clustered or spread are the data? Did everyone score close to the group average, or were there extreme scores that affect the average and cause it to fail to be a useful indicator for the data? Descriptive statistics and graphs assist in making this and other types of determinations about the data.

Inferential statistics are simply statistical tests used to compare scores of 1 or more groups. Statistical tests indicate if differences between or among groups are due to chance or greater than what would be expected due to chance. Some common statistical tests that are seen in the body psychotherapy literature are the t test (which is a set of calculations specifically designed to be used for 1 or 2 groups), analysis of variance or ANOVA (a set of calculations specifically designed to be used for 2 or more groups with the flexibility to accommodate more than one grouping distinction – for example groups defined by sex and diagnosis, and measurements repeated over time), Chi-squared, Mann-Whitney U, and Wilcoxon. The statistical test a researcher uses, so for example the t test, ANOVA, Chi-squared, et cetera, depends on the research design – the number of groups, type of data (scores vs. yes-no data, or none, some, a lot data – for example), and even the sample size or number of participants is a consideration in choosing the appropriate statistical test.

An Example

A brief example may be useful. If a researcher wished to study whether body psychotherapy (BP) reduced trauma symptoms of people diagnosed with post-traumatic stress disorder (PTSD) more than participation in cognitive behavioral therapy (CBT), he or she might select individuals with PTSD from the population and randomly assign them to either BP

or CBT treatment. This is an interesting choice because CBT represents an active control condition, as it is also an intervention favored for treating PTSD, and active control conditions create a stronger research design than control conditions where no alternative treatment is offered. Before and after the interventions, participants might be measured on a symptom inventory, and the difference between their scores before and after could be simply calculated by subtracting the score at post-test from the score at pretest. A smaller score at post-test creates a larger difference score (See Table 1) and, in this case, would indicate improvement or fewer symptoms at post-test than were reported at pretest.

Table 1 below shows the descriptive statistics for this pretend research. Inspection of the table shows that the number of participants per group (*N*), means or arithmetic averages (*M*) and standard deviations (*SD*), t test result (*t(df)*) and the probability of the t test result (*p*), have been reported. Note that means and standard deviations are reported for the pretest, the post-test, and the difference between the pretest and post-test scores. It is clearly seen that the participants in the BP treatment intervention, on the average, experienced a greater reduction in symptoms showing an average difference of 13.85 points on the symptom inventory than those who received CBT who showed only a difference or change of 3.64 points. In fact, the disparity between the means of these two groups is 10.21 (13.85 minus 3.64). But is that disparity between the groups meaningful or could it just be due to chance? The only way to answer that question is to use inferential statistics and submit the data to a statistical test.

*Table 1:
Descriptive and Inferential Statistics for Symptom Inventory Scores – BP and CBT Participants*

Group	N	Pretest (M, SD)	Post-test (M, SD)	Difference (M, SD)	t(df)	p
BP	13	31.08, 10.1	17.23, 6.7	13.85, 7.2	4.82 (25)	.001
CBT	14	30.57, 9.8	26.93, 9.9	3.64, 3.0		

In this example, the independent groups t test is an appropriate statistical test because as stated earlier, the t test is a set of calculations specifically designed to be used for two groups of participants, and the data on the symptom inventory meet the qualification of being interval level data (score points on the symptom inventory approximate equal intervals). So how is the t test result reported in Table 1 interpreted? The key feature of the result of the test is actually the probability value or p value (in Table 1, *p* = .001). In social sciences research, the probability values of results are typically evaluated by comparing them to .05 or .01. A small probability value (for example <.05 or <.01) associated with a statistical test result is interpreted as a statistically significant result. A statistically significant result indicates that the difference found between groups is not a chance difference. In this example in Table 1, the probability of the test result (*p*=.001) is smaller or less than .05 so this result is interpreted as statistically significant. Again, this means that the people who received BP improved more than the people who received CBT. The improvement in symptoms between the two groups (13.85 versus 3.64) is statistically greater than what would be expected due to chance. A statistically significant result such as this is interpreted as offering support for the research hypothesis that individuals with PTSD treated with

BP show more improvement (a greater reduction in trauma symptoms) than those treated with CBT.

Note that while the means and standard deviations – the averages and the spread around the averages – are displayed for the symptom inventory at pretest and at post-test, it is the scores created by subtracting the post-test scores from the pretest scores for each participant that are used in the statistical test (t test) between the two groups. It would be incorrect to separately test the scores at pretest and at post-test. That would indicate whether the groups were different from each other at pretest and whether they were different from each other at post-test. But it would not indicate how much each person in both groups changed in symptoms. In fact, the approach of testing the groups against each other at pretest and again at post-test has a name, the “wrong statistic in common use” (Campbell & Stanley, 1963 p. 23), because it fails to directly compare the quantity of interest which is the change from pretest to post-test for the participants that is expected to be due to the intervention.

When one reads quantitative research reports, it is important to keep in mind that statistical results such as the one demonstrated in the example are just one piece of evidence related to the study. In the example, it is important that participants were randomly assigned to the treatment groups as it addresses a potential bias, but one would also need to pay attention to other factors. For example, how well the central construct, PTSD, was measured and if its severity might have an impact on the research. More severe PTSD symptoms are more difficult to treat than less severe symptoms, so the researcher would need to make sure that the severity was the same in both groups. In addition, the measurement tool for noting symptoms and symptom change, would need to be one that was appropriate for and sensitive to PTSD symptoms. Also, the exact nature of the BP and the CBT treatments and who delivered the treatments should be carefully described and explained. The better the constructs and the participants are described, the better able the reader is to make decisions about the external validity of the study and whether generalizing is reasonable. Potential threats to internal validity and how they were controlled by the researcher need to be addressed. And, in the final analysis, the reader must also consider the sample sizes, which while sufficient for the statistical analysis, are intended in quantitative research to stand in for the population targeted by the research. Usually, there is more comfort in generalizing when the number of subjects representing the population is relatively large with respect to the size of the population, but in lots of research relevant for BP, sample sizes are somewhat small, like in the example used above. One of the very helpful aspects of meta-analysis, which will be described briefly below, is that it allows samples to be accumulated over many research studies, which can be very helpful in amassing evidence of treatment efficacy and effectiveness for a target population.

Beyond Statistical Tests

All research offers evidence, but in quantitative research the evidence can sometimes be confusing. In fact, research results can be equivocal. One study can support the hypothesis, but another can refute *the same hypothesis* due to results of statistical tests. The reason is that statistical tests combine sample size and effect size to create statistical significance. What this means is that the larger the sample, the more likely a researcher is to get statistical significance, and the converse is also true; the larger the

size of the difference between groups or the experimental effect, the fewer participants are needed for the researcher to get statistical significance. An antidote to this problem is meta-analysis, which involves replacing statistical testing with calculating effect size and then averaging effect sizes across studies to get a sense of the experimental effect across many research studies. Koch, Kunz, Lykou, and Cruz, (2014) used meta-analysis to systematically summarize the research on dance/movement therapy and dance for specific health and psychological outcomes. Because a single study is insufficient to establish the usefulness of any technique for any purpose, meta-analysis offers a good solution to the issue of equivocal results and usefully summarizes the research in specific areas (Cruz & Sabers, 1998). Especially in areas that need more research, meta-analysis can be more practical than Cochrane reviews where stricter criteria can greatly limit the number of studies allowed in the review so that average effect sizes cannot be calculated. Cochrane reviews are highly systematized reviews of research on specific topics that are touted as creating the highest standard for evidence-based care (<http://www.cochrane.org/cochrane-reviews>). However, when there are limited numbers of studies in a specific area, applying the stringent criteria needed for this type of review usually reduces the available information so much that the only result is that there is not enough information for an informed result.

Summary

This brief review and overview of quantitative methods explains how multiple, theoretical arguments are used to establish the value of quantitative research. Just like other skills, keeping one's quantitative research skills fresh takes attention. Practice improves one's comprehension and understanding. Reading and working to understand research results gets easier with experience. Reading research with colleagues allows individuals to pool their 'knowledge' resources and have fun at the same time (Cruz & Berrol, 2012). There are many wonderful resources on the Internet for learning more about quantitative research and even a quick search for an unfamiliar term while reading produces information that can greatly enhance one's understanding. Appendix A lists just a few online resources for getting started. We have also included a list of questions that can be used as one is reviewing research articles (see Appendix B). We hope that practicing reading quantitative research with this list and a group of like-minded colleagues becomes a useful exercise that brings benefits to both therapists and clients of BP therapists. It might even lead to written summaries on evidence for particular patient groups that might be quite useful for the process of professionally establishing guidelines in the health care system. In the UK the National Institute for Health and Care Excellence (NICE) guidelines, for example, include arts therapies for schizophrenia and psychosis in adults, children, and young people as a result of summaries of research. In Germany, summaries of research for particular patient groups can be submitted to the medical *Behandlungsleitlinien* (diagnosis related groups), and so far has led to the inclusion of dance/movement therapy as a recommended therapy for traumatized children, for breast cancer rehabilitation, and for Parkinson's disease. This in turn helps with employment, reimbursement, and recognition of the field within the health sciences. Regardless of whether written summaries help establish guidelines for an individual, a small practice, or contribute to a national database, this worthwhile activity of reviewing, discussing, and summarizing research can have cumulative effects that support the professionalization of body-oriented therapies.

Appendix A

Helpful Websites

- Statsoft, Inc. (2008). *Electronic textbook*. Retrieved from <http://www.statsoft.com/textbook/stathome.html>
- Niles, R. (2008). *Statistics every writer should know*. Retrieved from <http://www.robertniles.com/stats/>
- Oskar Blakstad (Feb 13, 2008). Statistics Tutorial. Retrieved Dec 29, 2014 from Explorable.com: <https://explorable.com/statistics-tutorial>

Appendix B

Questions to Guide Research Reading

1. What was the research question? (It should be clear.)
2. What was the research design? (This should be specified.)
3. Are there obvious threats to internal validity? (Hopefully no, but if so the author should discuss.)
4. How well were the major constructs defined? (There should be specificity to enhance external validity.)
5. How was the population defined? (This should be clear to enhance external validity.)
6. How were participants recruited? (They should be obvious members of the population.)
7. Was random assignment to group used? (When yes, it makes the design stronger.)
8. Was there diversity in the sample? (When yes, it makes the research more useful and generalizable; strengthens external validity.)
9. How well did the measures fit the constructs? (Measurement needs to fit the purpose.)
10. Are all important descriptive statistics reported? (M, SD, and N need to be given. This makes the research suitable for future analysis.)
11. What were the statistical results? (A statistically significant difference can support the research hypothesis – but authors should also report effect size.)
12. Were groups directly compared in a single statistical test? (A pre-post difference within each group is incorrect.)

BIOGRAPHIES

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Sabine C. Koch, PhD, Psychologist, BC-DMT, Prof. for Dance Movement Therapy at SRH Hochschule Heidelberg, Germany; is editor of "Body Memory, Metaphor & Movement" (John Benjamins) and of more than 100 research articles/chapters on the topics of dance movement therapy, embodiment, body memory, body feedback, movement observation, creative arts therapies, etc., one of them recently awarded with the Research Award 2014 of

the American Dance Therapy Association:

<http://journal.frontiersin.org/Journal/10.3389/fpsyg.2014.00537/abstract>

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WRITING ABOUT BODY PSYCHOTHERAPY

An invitation to write for us, with us, with support along the way. Your writing can contribute to and enrich the 'body' of critical and reflective content, as well as to the clinical expertise, in the 'field' of body psychotherapy.

Whom can you write for?

We suggest that – for a professional article – you consider:

The EABP/USABP peer-reviewed **International Body Psychotherapy Journal** (for original work only): www.ibpj.org

The peer-reviewed journal of Body, Movement and Dance in Psychotherapy (for original work only): www.tandfonline.com/toc/tbmd20/current#.VBfpFS6wJRU

Or: (for German language authors) **körper – tanz – bewegung**; Zeitschrift für Körperpsychotherapie und Kreativtherapie: www.reinhardt-verlag.de/de/zeitschrift/51830

(You will find the necessary “instructions for authors” on their various websites.)

Or: for something a bit more conversational: **Somatic Psychotherapy Today**:

<https://www.SomaticPsychotherapyToday.com>

Or: Something for a newsletter of your particular professional association, modality association, or national association in psychotherapy;

Or: A comment or a thread in one of the **Somatic Perspectives LinkedIn** group discussions, facilitated by Serge Prengel: www.linkedin.com/somaticperspectives.com

Or: Possibly, a chapter for an edited book, on a particular theme, possibly like one of the series being published by Body Psychotherapy Publications (**BPP**):

www.bodypsychotherapypublications.com.

Or: Something to be published somewhere else, at some other time, in a different medium; or for a personal internet blog; or . . . maybe just for your personal journal.

What can you write about?

You can write about attending a recent Congress, or seminar, or about attending a different event; - or about your student thesis; - or your experience of writing your student thesis; - or a special or particularly interesting case history; - or an aspect of your personal therapy; - or about working with a particular client group; - or about a development of theory or practice; or - even about your reflections on the field of Body Psychotherapy.

How to get started writing professionally?

There is an article in the journal of Body, Movement & Dance in Psychotherapy www.tandfonline.com/doi/full/10.1080/17432979.2010.530060#.VBfsNC6wJRU (You can also find a free copy here.)

And there are some recent guidelines about how to write a professional Body Psychotherapy Case Study: www.eabp.org/researchcase-study-guidelines.php. There are also many articles on the Internet (in different languages) about how to write.

If you want any further assistance with where to publish, or with the process of editing, or re-editing, or with the complications of the publication process, the following people may be able to offer you some help.

They are all professional body psychotherapists, editors and writers:

Nancy Eichhorn: Nancy@NancyEichhorn.com

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Sincerely,

EABP Publications Committee

<http://www.eabp.org/publications.php>

Squaring the Circle: Bridging the Gap Between Research and Practice About the EABP Collaborative Practice Research Network (CPRN)

The awareness of the importance of fostering different models of research, particularly those linked more closely to the actual practice of body psychotherapy and those encouraging a two-way communication between researchers and practitioners, has led to the creation of the EABP Collaborative Practice Research Network.

This is an exciting new initiative to provide a forum for dialogue, debate and the development of innovative and creative research methods and projects that assist clinical practice and help body psychotherapy (and/or somatic psychology) to develop an empirical underpinning of its professional practice.

The aim is to broaden knowledge of the field of body psychotherapy through communities of practice and clinical research. It explores how a CPRN can transform perceptions of psychotherapy research and practice, strengthen connections between members, and encourage continuous development and co-creation among participants. This important initiative is an opportunity to make a significant difference within our profession and to develop – together – the foundations of both scientific and clinical practice research.

Specifically, we are planning to explore and develop, at local and international levels, a variety of strategies to support practitioners' research and look at what types of research potentially provide a broadening of our understanding and practice of psychotherapy, and how various types of research advance, improve and extend our knowledge of body psychotherapy. We will do this by bringing together practitioners and researchers from around the world, both online and face-to-face, to discuss ways of bridging the gap between clinical practice and research.

The committee has organized two symposiums in conjunction with the 2012 and 2014 EABP Congresses. The next symposium will be held during the 15th European Congress of Body Psychotherapy in Athens Greece, 13-16th October 2016.

We would like to invite you to join us and become part of this exciting and innovative initiative. If you are interested please contact Sheila Butler and Herbert Grassmann - cprn@eabp.org

EABP Science and Research Committee - Sheila Butler, Herbert Grassmann (chairperson), Frank Röhrich, Maurizio Stupiggia, Joop Valstar, Courtenay Young and Jennifer Tantia www.eabp.org/research-scientific-committee.php

Strengthening links between practitioners and researchers at every stage of the process

News:

The Society for Psychotherapy Research (SPR), an association devoted to the development and dissemination of research on psychotherapy has some exciting upcoming SPR events:

- *The International Annual Meeting in Philadelphia, USA* in June 2015 from 24th to 27th June.
- *The European Conference on Psychotherapy Research* in Klagenfurt, Austria, September 24th to 27th, 2015, and the planned 2016 International Meeting in Jerusalem, Israel in June 2016.

You might also like to browse the Psychotherapy Research Journal pages, especially the Special Issues and the online resources; there is a lot of information on the integration of theoretical, empirical and clinical knowledge in psychotherapy. See <http://www.psychotherapyresearch.org>

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THE ART AND SCIENCE OF SOMATIC PRAXIS

INCORPORATING US ASSOCIATION FOR BODY PSYCHOTHERAPY JOURNAL

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Guest Editor: Jennifer F. Tantia, PhD, BC-DMT

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